



Well-being of the Rohingya Children in Refugee Camps in Bangladesh: Strategies, Coping Mechanism and Challenges of the Support Systems

Bangladeř'teki Mülteci Kamplarındaki Rohingya Çocuklarının Refahı: Stratejiler, Başa Çıkma Mekanizmaları ve Destek Sistemlerinin Zorlukları

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Abstract

The Rohingyas are one of the ethnic minority groups of Myanmar. Despite their long history in Rakhine State, they were made stateless by the government of Myanmar in 1982 by enacting the Burma Citizenship Act of 1982. They have endured communal violence, resulting in death, forced displacement and migration, and are, experiencing ongoing traumatic events, particularly among women and children. They have become victims of torture and persecution, with females enduring rape and many witnessing their loved ones brutally killed before their eyes. These life events have a profound impact on their physical and mental well-being, even now while they are living as refugees in camps in neighboring Bangladesh. Due to numerous associated issues, recent history has witnessed a complex emergency involving internal and external displacements of individuals from this ethnic minority group, rendering them refugees in various countries, including Bangladesh. This article is focusing on the Rohingya children's physical and mental well-being, who are almost 52% of the total Rohingya refugee population living in the camps in Bangladesh. This study, drawing on secondary data, presents evidence of the well-being of the Rohingya children in Bangladeshi refugee camps and investigates the challenges they face and their coping mechanisms in these situations. This article sheds light on current conditions and outlines the future directions for support and research.

Keywords: Bangladesh; Complex Emergency; Myanmar; Physical and Mental Health; Refugee Camps; Rohingya Refugees; Rohingya Children; Trauma; Well-being.

Öz

Rohingyalılar Myanmar'da yaşayan etnik bir azınlık topluluğu olup; Myanmar'ın Rakhine Eyaletindeki uzun geçmişlerine rağmen, 1986'da vatansız kalmışlardır. Bu bağlamda Rohingyalılar ölümlerle, zorla yerinden edilmeyle ve göçle sonuçlanan toplumsal şiddete maruz kalmış özellikle kadınlar ve çocuklar bir çok travmatik olaylar yaşamışlardır. İşkence ve zulmün kurbanı olmuşlar, kadınlar tecavüze uğramış, ve birçoğu sevdiklerinin gözlerinin önünde vahşice öldürüldüğüne tanık olmuşlardır. Tüm bu travmatik yaşam olayları, komşuları olan Bangladeř'teki mülteci kamplarında yaşarken dahi Rohingyalıların fiziksel ve zihinsel sağlıklarını derinden etkilemiştir. Yakın tarihe bakıldığında bu etnik azınlık gruba ait bireylerin gerek ülke içerisinde gerekse dışarıda pek çok sorunu göğüslemek zorunda olduğu görülmüştür. Bu sorunlardan biri de ülke içinde ve dışında yerlerinde edilerek Banladeř'te mülteci durumuna düşmeleridir. İkincil verilerden yararlanan bu çalışma, Bangladeř mülteci kamplarındaki Rohingyalı çocukları karşılaştıkları zorlukları ve başa çıkma mekanizmalarını incelemekte; iyi oluşlarının desteklenmesi yönünde bir takım kanıtlar sunmaktadır. Bu makale mevcut koşullara ışık tutmakta ve destek ve arařtırmalar için gelecekteki yönelimleri özetlemektedir.

Anahtar Kelimeler: Rohingyalı Çocuklar; Karmařık Acil Durum; Mülteci kampları; Ruh Sağlığı; Travmatik Anılar.



Introduction

The Rohingyas, an ethnic minority, have been enduring statelessness as residents of Rakhine State, formerly known as Arakan, in Myanmar (Figure 1). Their struggle began during the British reign when the Rohingyas remained loyal to the British while the Rakhine Buddhists sided with the Japanese who tried to invade Myanmar in 1942 (Milton et al., 2017; Moniruzzaman, 2021). However, their misery reached its peak in 1982, when they were denied a fundamental human right - citizenship, which would enable them to be an integral part of the cohesive society in their homeland (Amnesty International, 2015). The Rohingyas face substantial and persistent human rights violations that include denial of citizenship, restrictions on migration, restricted access to education and medical care and obstacles to wedding, childbirth, and religious practice (Riley et al., 2021). The violation of their human rights is extensively documented by international human rights organizations and UN reports (Human Rights Council, 2018; Shohel, 2022 & 2023).



Figure 1. Map showing locations of Rakhine State where the Rohingyas live in Myanmar and Cox's Bazar District in Bangladesh where most of the refugee camps for Forcibly Displaced Myanmar Nationals (FDMNs) are based (Adapted from Asrar, 2017; Shohel et al., 2023b).

The Rohingya Crisis

The Rohingyas are 'fleeing crimes against humanity' from their homeland (Human Rights Watch, 2018). The latest exodus began on 25 August 2017 when the military launched targeted violence in Myanmar's Rakhine state. Human Rights Watch (2018) clearly stated that the regime of Myanmar is to blame for the Rohingya refugee crisis and that addressing would require substantial and long-term changes in Myanmar. As a prerequisite for individuals to return in peace and dignity, the state of Myanmar must assure full respect for refugees' rights as individuals, equitable access to nationality, and safety among the population of Rakhine State. It also recommended that various states and multilateral organizations exert "consistent and constant pressure on Myanmar to fulfill every requirement essential for the secure, respectable, and permanent reintegration of Rohingya refugees" (p. 11).

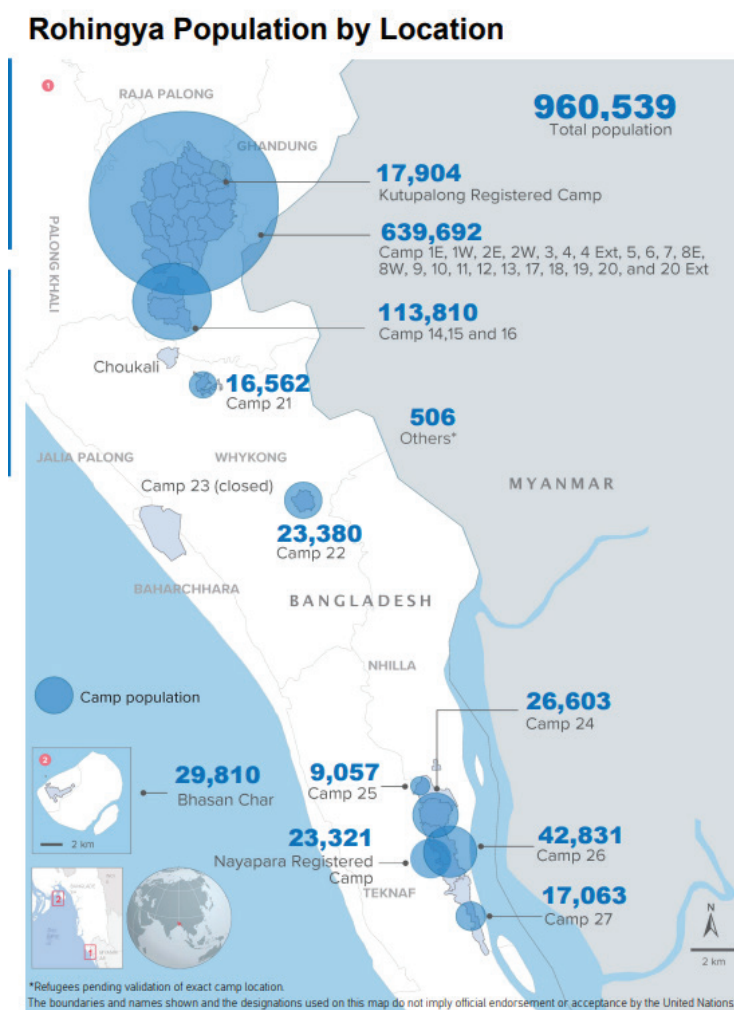


Figure 2. Rohingya Refugee Population by Location (adapted from GoB & UNHCR, 2023).

Source: <https://data.unhcr.org/en/documents/details/100047>

Since the early 1990s, over a million Rohingya refugees have fled from Myanmar to Bangladesh because of violence, torture, and persecution in successive waves of displacement. The Rohingyas sought safety in neighboring Bangladesh, and many of them are now living in Kutupalong, one of the world's largest refugee settlements (UN Joint Response Plan, 2018). The majority of these refugees are children, accounting for over 52% of the people living in the camps (UNHCR, 2023). These children are particularly vulnerable to child labor, sexual exploitation and human trafficking. The overcrowded conditions in the refugee camps exacerbate pre-existing problems, such as gender inequality, gender-based violence, and discrimination (Shohel, 2022 & 2023; UN Women, 2018).

Table 1. Number of the Rohingya refugees who entered Bangladesh in different times (Shohel et al., 2023a, 2023b)

Year	Number of Refugees (approx.)	Source(s)
1942	22,000	Human Rights Watch (HRW) (2000)
1977-78	200,000	MSF (2022); Islam et al. (2022)
1991-92	250,000	HRW (2000); Kiragu et al. (2011)
2016	80,000	HRW (2018)
2017	700,000	Reid (2021)
2018	11,432	HRW (2018)

The humanitarian crisis in refugee camps continues unabated, with children's vulnerability being repeatedly exploited. They fall prey to traffickers and pedophiles. For instance, there are reports of a rampant sex trade in Cox's Bazar that targets the Rohingya girls aged between 13 and 17 years, who are trafficked and forced to work as sex workers in India. The extent of this sex trafficking network was uncovered by a BBC undercover investigation (Amnesty International UK, 2018). Cox's Bazar refugee camps, as situated very close to the Indian border, have high risks of sexual exploitation and trafficking of children and young girls, inevitably raising questions about how these practices contribute to an increased risk of HIV infections among the Rohingya population.

Physical and Mental Health Crisis of the Rohingya Refugees

One of the most devastating incidents endured by the Rohingya refugees was confiscating or destroying their personal property. At least 75% of the refugees reported having their personal property confiscated or destroyed. Of them, 65% were beaten inhumanely. 12.8% of families living in the Rohingya camps experienced sexual exploitation, 8.1% were sexually assaulted, and 6.1% had witnessed physical or sexual violence and abuse before, during, and after they fled from their homeland (Riley et al., 2017). The concrete number of secondary deaths of girls and women due to sexual violence is unclear. However, Médecins Sans Frontières (MSF) estimates that at least 2.6% of those assaulted have died (Goodman & Mahmood, 2019).

Conflict, Violence, Sexual Exploitation, and Trafficking. Gender-based violence (GBV) includes sexual humiliation of the Rohingya women and girls, sexual assault on the Rohingya women, mutilation of their reproductive organs, and an effort to break the spirit of the Rohingya women by raping them in the presence of their family and community. This resulted in public humiliation, rejection from the spouse and society due to rape stigma. Other incidents include land expropriation, eviction, and unrestricted immunity*. These disturbances and life-events caused psychological well-being issues such as self-destruction, including suicide among youngsters, and an elevated degree of mental difficulties and post-traumatic stress disorder (PTSD) in the female Rohingyas (Tay et al., 2019; Fischer et al., 2021; Hossain, 2023). Additionally, children who witnessed these crimes were beyond terrified, and many of them have trauma and PTSD (Anwary, 2022).

According to Riley et al. (2017), the most common mental disorders faced by the Rohingya community are as follows:

Post-traumatic distress symptoms. Khan and Haque (2021) reported that 36% of the participants in the study had PTSD-related symptoms. The indicators with the greatest mean intensity were: feeling as though they did not have a destiny; recurring ideas or recollections of the worst or most frightening experiences; feeling on guard; and reduced interest in everyday activities.

Depressive symptoms. 89% of participants said they had depression-like symptoms in a quantitative research conducted by Ritsema and Armstrong-Hough (2023). The symptoms with the greatest mean intensity ranged from feeling pessimistic about the future to feeling exhausted or sluggish, feeling unworthy, and worrying excessively. Notably, 13% of interviewees expressed that they encounter frequent suicide ideas (Ritsema & Armstrong-Hough, 2023).

Additional serious mental health symptoms. Participants who indicated that they experienced the following indications "most of the time" or "all of the time" in the previous two weeks are given percentages: feeling so terrified that nothing could calm them down (14%); feeling so outraged that they

*The "unrestricted immunity" term refers to a situation where individuals or entities involved in acts of gender-based violence, such as sexual assault, mutilation, or rape, are able to act without facing legal consequences or being held accountable for their actions. This suggests that those responsible for such heinous acts are not subject to legal prosecution or punishment, allowing them to act with impunity. In essence, they have immunity or protection from legal consequences, which contributes to their lack of accountability.

felt beyond control (9%); having their firmly held suspicions confirmed by family or friends as being strange (5%); hearing voices (3%) and seeing things (2%) that were not real (Christensen & Ahsan, 2022).

Physical symptoms. Respondents often self-reported multiple physical symptoms for their mental distress, including headache (67%), backache (55%), feeling burnt in the head, stomach, or whole body (50%), general pain (49%), and gastrointestinal (dyspepsia) problems such as chronic constipation (49%) (Green et al., 2022; Haider et al., 2023).

Wellbeing of the Rohingya Children: Physical and Mental Wellbeing

Physical Wellbeing

Most Rohingya refugees reside in the hilly neighborhoods of Cox's Bazar, particularly Nayapara and Kutupalong, where acquiring the basic necessities is a challenge. Consequently, the three primary issues in the Rohingya camps revolve around food scarcity, access to health care (Reid, 2023; UNDP, 2018), and escalating public health demands. Infectious diseases, including cholera, diarrhea, and pneumonia, are on the rise due to various factors such as inadequate access to clean water, food shortages, forced relocations, severe violence (Akhter et al., 2020), poor health care, poor sanitation, and overcrowding (UNDP, 2018).

Additionally, 60% of the newly arrived Rohingya refugees after the influx in 2017 were women and girls, of whom 10% were pregnant and breastfeeding mothers. It is estimated that 50,000 Rohingya refugee women were pregnant. However, a significant proportion of pregnant women did not have access to quality prenatal care. The biggest health problems of the Rohingya refugees are unexplained fever, acute respiratory infections, and diarrhea. Non-communicable diseases and their risk factors, such as hypertension and diabetes, are also prevalent among these populations (Joarder et al., 2020).

Medical complexes and local hospitals are increasingly focused on responding to the urgent needs of refugees. Therefore, the local health care system is severely strained by serving the Rohingya refugees, and as a result, local communities are not receiving enough health care support. The Civil Surgeon of Cox's Bazar claimed in an interview that 4,444 health centers were overwhelmed during the emergency period, serving both the Rohingyas and the local population (UNDP, 2018).

Furthermore, children living in the Cox's Bazar Rohingya camps face various vulnerabilities, including inadequate living spaces, limited access to nonformal and formal educational opportunities, insufficient nutrition services, and numerous protection concerns such as child marriage, child trafficking, drug abuse, drug trafficking, and abduction by extremist groups within the camps. For example, an assessment report found that the lack of education opportunities was one of the main stressors (among 43% of the participants), negatively impacting the mental and psychosocial well-being of the Rohingya children (IOM, 2021). A study indicates that child protection concerns within the Rohingya camps encompass neglect (16%), physical abuse (15%), verbal abuse (15%), and child marriage (13%). The findings reveal a comparatively high incidence of physical punishment (23%) and sexual violence among those aged 13-17 (16%) in the Rohingya community (UNICEF, 2021).

Mental Wellbeing

The psychological distress stemming from the harrowing experiences personally endured by the Rohingya people has had a direct and profound impact on their mental health. Insights into their state of mind can be gleaned from the experiences and overwhelming feelings of helplessness discussed in the following subsection. More than 52% of children aged between 2 and 16 exhibit abnormal ranges for emotional

symptoms, and 25% show abnormal ranges for peer-related issues. Notably, emotional symptoms were found to be abnormal in 100% of children without parents, compared to 57.8% of children with parents. Acts of violence, deliberate assault, and sexual violence typically result in anxiety attacks, infections, and post-traumatic disorders among children and women, contributing to significant mental and social distress (Zaman et al., 2019).

The psychological stressors experienced by the Rohingya refugees were widespread and closely linked to social instability, indicating a pervasive sense of insecurity, a lack of employment opportunities, and a long history of trauma. Disputes with other family members on a daily basis were identified as the primary source of their psychological anguish. A substantial number of female respondents expressed feelings of anger and imprisonment, stemming from being compelled to leave their homes in Myanmar and live at the mercy of strangers in the camps (Cairns, 2017; Masood & Uddin, 2020; Wake & Chueng, 2016).

Studies indicate that common mental health issues or disorders among refugee children include worry, fear, low mood, and a sense of uncertainty about current safety (akin to anxiety, depression, and symptoms of PTSD) (Frounfelker et al., 2019). Among the total Rohingya population of 960,539 (GoB & UNHCR, 2023), 52% of children have been one of the most vulnerable groups, facing substantial challenges related to their mental health and well-being. According to an INGO official, "mental health is one of the most significant yet overlooked needs in the camps. The trauma from Myanmar is compounded by the stresses here" (cited in Human Rights Watch, 2018, p. 35-36). One of the objectives of this study is to explore the mental health challenges faced by the Rohingya children in Bangladesh.

The mental health challenges faced by the Rohingya children are intricate and multifaceted. These children have been exposed to a range of traumatic experiences, including violence, forced displacement, and the loss of family members and loved ones (Shohel et al., 2022). Riley et al. (2017) and Shohel et al. (2022) have highlighted that these experiences can significantly impact their mental health and well-being, resulting in symptoms such as anxiety, depression, post-traumatic stress disorder (PTSD), and behavioral issues. These challenges are often exacerbated by the lack of access to essential services and resources, including education, health care, and social support, necessary for promoting mental health and well-being.

Causes Impacting the Wellbeing of the Rohingya Children

A rapid needs assessment conducted by the International Organization for Migration (IOM) in 2018 revealed that the Rohingya children in Cox's Bazar, Bangladesh, were grappling with high levels of stress, anxiety, and depression. The report indicated that 51.2% of the Rohingya children aged 4-14 years displayed symptoms consistent with post-traumatic stress disorder (PTSD). Similarly, the International Medical Corps (2018) reported that 54% of the Rohingya children aged 7-17 years experienced severe emotional distress. Another needs assessment by the IOM in 2021 further highlighted that anxiety, uncertainty about the future, and poor concentration among children contributed to their emotional distress (IOM, 2021). Thus, we can conclude that anxiety and feelings of uncertainty were significantly present in those four years among the children. Another report by UNHCR (2020) echoed these findings, underlining that the Rohingya children in Cox's Bazar were at risk of developing mental health and psychosocial problems due to the traumatic experiences they had endured. As recommendations, the UNHCR (2020) report emphasized the importance of providing children with safe spaces for play and learning, along with access to mental health and psychosocial support services so that the Rohingya children can get help for their mental health problems.

Despite these challenges, the Rohingya children have demonstrated resilience and developed coping mechanisms to deal with the stressors in their lives. A study by Save the Children (2019) found that

many Rohingya children in Bangladesh, especially adolescent girls, resorted to negative coping mechanisms such as child marriage and drug abuse, which are now being addressed by various service providers through social support networks, engagement in recreational activities, and participation in community events. The report noted that these coping mechanisms played a crucial role in the mental health and well-being of children. However, frequent relocations, inadequate access to basic services, and poor living conditions, coupled with restrictions on movements both within and outside the camps, can contribute to toxic stress that overwhelms children's ability to adapt and cope with such adverse environments. Additionally, the Rohingya children are facing unique challenges related to their identity and social exclusion. As stateless individuals, they are denied citizenship in Myanmar and are yet to be recognized as 'refugees' by the Government of Bangladesh. This state of limbo can foster a sense of insecurity, hopelessness, and despair, further exacerbating their mental health issues.

Refugees suffering from psychological anguish, trauma-related stress disorder, and other emotional wellness issues are particularly vulnerable. Human Rights Watch (2018) reported Myanmar security forces used gang rape and other types of sexual abuse against the Rohingya women and girls during the 2017 ethnic cleansing operation. Victims of sexual violence frequently experience both physical and serious psychological problems such as post-traumatic stress disorder, complex trauma, anxiety, or despair. In 2017, extreme overcrowding in Bangladesh's inadequate health care facilities, along with shame and a lack of awareness about how to get support, prevented the Rohingya rape survivors from accessing health care. The scenario has improved because of greater communication, particularly personalized case handling and the construction of women-friendly centers. Despite this, it is claimed that numerous victims continue to lack access to long-term trauma care and other critical services.

During the COVID-19 pandemic, the mental health of the Rohingya children was significantly affected by family disputes. Conversations with frontline staff members revealed that the Rohingya women experienced intimate partner violence due to financial difficulties. Violence between husbands and wives in the family was identified as a direct result of the family's financial insecurity. With many educational and other services for children closed down, children spent most of their time at home. Mothers reported that, while staying at home, fathers sometimes lacked support and grew agitated when children made noise. As a result, mothers had to shoulder full responsibility when the children acted out. They believed that fathers should receive guidance on how telecommunication platforms promote and benefit children, allowing children more time for education over the phone. Fathers would be more interested in and aware of the value of such initiatives if they were made clear about the nature of these activities. Almost all fathers emphasized that men could receive the same information as mothers and could handle the tasks when mothers were occupied (Rahman et al., 2023).

Support Systems of the Rohingya Children: Reality and Challenges

The provision of mental health and psychosocial support services for the Rohingya children remains a considerable challenge, primarily due to limited resources and a shortage of trained professionals. A report from the Cox's Bazar Child Protection Sub Sector (2021) underlines the pressing need for increased investment in mental health and psychosocial support services for the Rohingya children and their parents. It emphasizes the importance of engaging with community members and enhancing their capacity to provide support to children. It is evident that there is a severe shortage of qualified medical and mental-health professionals, and the population requires sustained assistance. Ongoing issues, such as hygiene, well-being, and basic health-related matters, can be addressed by raising awareness among the population. Utilising technology may offer a solution for expanding the support network to reach more refugees (Zaman et al., 2019).

Other studies have emphasized the significance of home-based and community-based support, the creation of safe spaces, and parenting as means of promoting mental health and overall well-being. For instance, a report by Humanity and Inclusion (HI) recommended the development of problem-management skills and increasing awareness of positive coping strategies as effective approaches to reduce stress among parents at home, subsequently alleviating stressors for children (HI, 2019).

The mental health and well-being of the Rohingya children remain a pressing concern, necessitating a multifaceted approach. This approach could encompass access to safe spaces, specialized mental health and psychosocial support services, and parental and community support. While children have demonstrated resilience and developed coping mechanisms, more efforts are required to ensure they receive the necessary support to thrive.

Humanitarian Aid for Wellbeing Purpose

Substantial humanitarian aid is required to provide health care services to the millions of the Rohingya refugees, which could significantly enhance their well-being. Organisations like the World Health Organization (WHO), UNICEF, and others have collaborated with the Bangladesh government to address these issues. A massive Oral Cholera Vaccination (OCV) campaign was launched in October and November 2017 to prevent the spread of the disease among the Rohingya children over the age of 1. OCV offers 40% protection in a single dose when administered to children older than 1. In Ukhiya and Teknaf, where they had already successfully administered 650,000 doses to children, WHO and UNICEF organized a campaign to administer 900,000 doses of the OCV vaccine. (UNICEF, 2017a).

According to the Bangladesh Ministry of Health and Family Welfare, 82% of children under 5 years of age were suspected of having had diphtheria and measles. With the assistance of the WHO and UNICEF, a program to prevent measles, diphtheria, and rubella was initiated. The WHO established the Early Warning Alert and Response System (EWARS) to enhance the monitoring of illnesses during emergencies and detect outbreaks. EWARS is a mobile app and web-based system (local server) that can track communicable diseases and outbreaks in any location and dispatch appropriate support. It is being used to detect measles, acute jaundice syndrome (AJS), and diphtheria in Ukhiya and Teknaf in Bangladesh (Mazhar et al., 2021; Rahman, 2018).

Efforts by the Bangladeshi government to relocate the Rohingya are also ongoing. While support for physical health is relatively straightforward, providing mental health support remains challenging, given the traumatic past experiences of the Rohingyas (Zaman et al., 2019). To improve children's developmental outcomes and well-being on a larger scale in humanitarian settings with implications for local and global communities, the Bangladesh Rural Advancement Committee (BRAC) has adopted a model designed to integrate learning and healing through play. The Healing through Play and Learning (HPL) model was formally introduced in 2019 for three age cohorts of children aged 0-2, 2-4, and 4-6 (Mariam et al., 2021).

The model involves a home-based (HB) intervention targeting pregnant women and mothers of young children, providing counseling on parenting, mental health, the parent-child bond, and the importance of play in early childhood development. In addition, a centre-based (CB) intervention is conducted, which involves a comprehensive, play-based curriculum that includes art therapy, physical activities, chanting, and regional rhymes and stories known as Kabbya and Kissa. The primary service providers in this program are Play Leaders (PL) and Mother Volunteers (MV). PLs, who are the Rohingya women, engage with the children, oversee playtime, and encourage it. MVs, also chosen from the Rohingya community, conduct group and one-on-one sessions for mothers of young children (0-2 years old) in their homes on a weekly basis. Both PLs and MVs are paid employees who receive a daily wage of BDT

300. This program is supported by the BRAC Institute of Educational Development (IED) through the Play to Learn (PtL) program, funded by the LEGO Foundation (Mariam et al., 2021; Rahman et al., 2023).

Research Questions

This article focuses on the well-being, both physical and mental, of the Rohingya children, and outlines possible interventions and policy directions to safeguard the rights of children in the refugee camps in Bangladesh. This study considered to explore the following research questions:

- What are the well-being issues and challenges faced by the Rohingya refugee children in Bangladesh?
- What coping mechanisms do the Rohingya refugee children employ to deal with their well-being issues and challenges?
- How can the Rohingya refugee children be better supported based on the available evidence?

Methodology

This review article draws upon a wide range of literature, including academic and grey literature. As the authors of this article, we have meticulously assessed the credibility and reliability of the grey literature included in this review (Greene et al., 2017). A systematic approach, guided by Jesson et al. (2011), was employed to conduct literature searches via 'Google', 'Google Scholar', 'Mendeley', 'Social Science Research Network' (SSRN), and 'ResearchGate'. These searches were conducted to collect documents related to the well being of the Rohingya children living in Bangladesh. The search involved the use of keywords such as 'Rohingya', 'Rohingya Children', 'Rohingya Crisis', 'Refugee', 'Rohingya Refugee Children', 'Refugee Camps', 'Myanmar', and 'Bangladesh' to explore the impact of the Rohingya crisis on the externally displaced Rohingya refugees residing in Bangladeshi refugee camps. This process included the collection of both freely available academic and non-academic documents written in English. Subsequently, the selected literature was analyzed to extract secondary data and complete the review.

Findings and Discussion

In this section, the findings obtained in line with the research questions are presented below respectively.

Well-being Issues and Challenges for the Rohingya Refugee Children in Bangladesh

This article presents strong evidence of the profound impact of children's experiences on their mental health, particularly in terms of abnormal levels of emotional symptoms and peer problems. According to the Strengths and Difficulties Questionnaire (SDQ), 52% of children exhibited abnormal emotional symptoms, and 25% displayed abnormal peer problems (Khan et al., 2019). Living conditions within the camps, limited opportunities for play, and the fact that 50% of children reside with their grandmothers or extended family members, resulting in inadequate adult supervision to observe and nurture behaviors such as sharing and cooperation, played pivotal roles in these findings (Shohel, 2023). Children who are parentless or have lost one or more family members during the recent crisis are identified as being at significant risk.

Despite these difficulties, just over one percent of worldwide emergency assistance is dedicated to protecting children's psychological well-being (Save the Children, 2019), although 30.4% of refugee

children struggle with psychological disorders, 26.8% suffer from anxiety, and 21.4% suffer from sorrow (Betancourt et al., 2012). Local relief personnel, families, and caregivers in the Rohingya refugee camps lack sufficient training and tools to address the children's particular problems. Present early childhood development (ECD) training is difficult to obtain frequently due to typical obstacles such as transportation expenses, a shortage of time off for training, unsuitable training places, the requirement for funding to participate, and the duration or frequency of training sessions (Mansur, 2021).

Refugees in Bangladesh are unable to work lawfully, which has led many refugees, particularly males, to seek unlawful employment to sustain themselves. Research has shown that refugees with paid employment are less likely to experience signs of acute distress compared to those without jobs (Ansar & Khaled, 2021). Male refugees, in particular, exhibit a higher prevalence of symptoms of traumatic distress. Individuals without literacy skills are more likely to experience severe mental health problems compared to refugees with some level of education. Currently, adult refugees have limited access to education in the camps, and job placements are not based on educational background (Hossain et al., 2021). This absence of formal education and employment opportunities, and unstable living conditions among refugees in Bangladesh not only hinder their individual well-being but also contribute to heightened insecurity and anxiety, particularly impacting children and adolescents.

Studies (Shohel et al., 2022; Shohel, 2023 & 2022; Ullah et al., 2023; UNHCR, 2018) have revealed a high incidence of various mental health issues among the Rohingya children, including symptoms commonly associated with PTSD and depressive disorders. Additionally, there is a notable prevalence of behavioral health problems, such as suicidal thoughts, impulsive rage, psychotic-like symptoms, unexplained physical manifestations, and other symptoms. A study conducted by UNHCR found that 50% of respondents, who were the Rohingya parents or caregivers, had observed distressing emotional symptoms or behavioral changes in their children. These included increased weeping and sorrow (67% of girls and 59% of boys), disrespectfulness (41% of girls and 40% of boys), aggression (23% of girls and 38% of boys), and drug misuse (14% of girls and 31% of boys). Factors contributing to these changes included exposure to sexual violence before their displacement (44% girls and 10% boys), memories of violence (78% boys and 66% girls), separation from home (44% boys and 32% girls), and fear of returning (Tay et al., 2018).

The Rohingya minors and young people, among the world's most vulnerable children, have endured some of the worst consequences of conflict-induced displacement (Shohel, 2023). They have witnessed and experienced brutality, oppression, and marginalization on their home soil. The situation in Bangladesh is equally challenging, with children facing daily hardships, limited scope in education and future employment, oppression, deprivation, marginalization, and brutality (Shohel et al., 2022). This has resulted in constant fear, uncertainty, and insecurity related to food and health. Organised crime, including human trafficking, border smuggling, and illegal arms trading, has subjected them to drug trafficking, sexual enslavement, and exploitation (Shohel, 2022).

Most teenagers in the camps lack access to education and often suffer humiliation, physical abuse, child marriage, child labor, human trafficking, kidnapping, and exploitation (UNICEF, 2017b). Several studies have confirmed that 60% of refugee children suffer from PTSD due to the horrors they have witnessed. Their physical security is under constant threat, their personal identity is diminished, and access to food, nutrition, and family life is disrupted, while their education prospects remain uncertain (Kinch, 2008). In addition, children with special needs who are unaccompanied suffer from separation anxiety and endure flashbacks to their traumatic past (Kinch, 2008).

The Rohingya children also face health issues, including respiratory problems such as tuberculosis and pneumonia, malaria, malnutrition, micronutrient deficiencies, anemia, parasite infestations, diarrhea, dysentery, and injuries from physical abuse such as fractures, dislocations, burns, lacerations, and abrasions (Murray, 2016; Snow & Sissons, 2012). About 7% of the children in the camps are suffering from severe acute malnutrition, a fatal condition without proper care. Furthermore, outbreaks of communicable diseases such as measles and diphtheria have occurred in the overcrowded camps (Beech, 2018; Chattoraj et al., 2021). Approximately 60% of the water wells in the camps are contaminated with fecal matter from latrines located too close to drinking sources, posing risks to children's health (Ullah et al., 2022).

At present, almost one million Rohingya refugees, over fifty percent of them less than the age of 18, are staying in 34 refugee camps in Ukhia and Teknaf Upazilas of Cox's Bazar district. In a recent study, 3.7% of the Rohingya adolescents exhibited signs of PTSD, 12.5% displayed symptoms of major depression, and over half (55%) exhibited signs of at least mild depression. The Rohingya adolescents have been exposed to traumatic events such as being close to death (48.3%), combat situations (41%), and torture (41%), which have contributed to a 5% increase in PTSD scores and a 30% increase in major depression (O'Connor & Seager, 2021).

Field studies reveal that among the Rohingya population, psychosis (35%), depression (22%), and anxiety (10%) are the most prevalent mental health issues. Many patients reported experiencing flashbacks, nightmares, aggressive behaviors, suicidal thoughts, delusions, and drug abuse. However, a significant portion of patients who experience depression, PTSD, schizophrenia, and psychosis often go unrecognized by their community, as these conditions may be attributed to cultural beliefs or a lack of trust in camp medical, psychiatry, and mental-health professionals. Additionally, the isolation and loneliness of patients make it challenging for mental health professionals attempting to support the Rohingyas. Restrictions on communication with family members outside the camp exacerbate the situation. Many patients cannot communicate with their families in Cox's Bazar or Myanmar due to travel and telecommunication restrictions, leading to further distress (Dyer & Biswas, 2019).

Coping Mechanisms to Deal with Wellbeing Issues and Challenges

Coping mechanisms refer to the strategies individuals employ to manage and adapt to stressors, challenges, and difficult circumstances (Tachè & Selye, 1985). They play a vital role in promoting resilience and psychological well-being. The Rohingya refugee crisis has significantly affected the well-being of the Rohingya children, who have encountered numerous challenges related to their mental health and overall well-being (Shohel et al., 2022). As these children navigate the hardships of displacement, understanding the coping mechanisms they employ to address their well-being issues and challenges is essential for better supporting them.

For the Rohingya children who have experienced displacement, loss, and ongoing adversity, understanding their coping strategies is crucial to identify their strengths and develop effective support interventions. Given the unique cultural context and experiences of the Rohingya children, it is important to consider both individual and collective coping mechanisms. Individual coping strategies may encompass emotional regulation, seeking social support, engaging in recreational activities, religious and spiritual practices, and cognitive reframing. Collective coping mechanisms may involve community support, cultural traditions, and social cohesion within the Rohingya community.

While existing literature (Betancourt & Khan, 2008; Dangmann, 2022; Fazel & Betancourt, 2018) offers valuable insights into coping mechanisms among refugee children, research specifically focused on the Rohingya children is limited. One significant coping mechanism observed among the Rohingya children

in the refugee camps in Cox's Bazar is their resilience and resourcefulness in forming social networks and support systems. Despite the challenging conditions, children often establish strong bonds with their peers, neighbors, and extended family members. These social connections provide emotional support, a sense of belonging, and opportunities for sharing experiences and coping strategies. Collective strength and solidarity within the Rohingya community contribute to their ability to withstand and navigate their challenging circumstances. Evidence suggests that almost two-thirds (65%) of teenagers reported regularly spending time with their peers to alleviate stress. Most teenagers have reliable connections with their parents, who serve as their primary providers of assistance and support (Guglielmi et al., 2020).

Religious and spiritual practices hold a significant place in the lives of the Rohingya people and play a central role in coping with mental health and psychological issues. Mosques and Madrasas are prevalent in the camps, where children actively engage in religious rituals, prayers, and the recitation of the Quran. These practices offer comfort, guidance, and a sense of purpose and hope despite adversity. Religious leaders and teachers often play a crucial role in providing counseling and support to children, promoting their well-being and resilience (Chen, 2018; Duchesne, 2016; Shakespeare-Finch et al., 2014; Tay, 2019).

Play and recreational activities serve as essential coping mechanisms for the Rohingya children in the camps. Despite limited resources, children find ways to engage in play, including traditional games, sports, and creative activities. Play not only provides a temporary escape from the challenging environment but also allows children to express themselves, process their experiences, and develop essential life skills. Humanitarian organizations and non-government organizations (NGOs) working in the camps often facilitate the establishment of safe spaces and child-friendly areas, providing opportunities for play and recreational activities (Corbit et al., 2022; Mariam et al., 2021).

Education and learning also play a vital role in the coping strategies of the Rohingya children. Education equips children with knowledge and skills that offer a sense of purpose and a pathway for building a better future (Shohel, 2010). Access to nonformal education in the camps, though limited, provides children with a sense of normalcy, hope for the future, and opportunities for personal development. Schools and learning centers in the camps offer structured routines, social interaction, and a safe environment for children, contributing to their overall well-being and resilience (LCFA, 2018).

It is important to note that the coping practices observed within the Rohingya community in the camps can vary among individuals and are influenced by factors such as age, gender, and personal experiences. Some children may engage in more active coping strategies, such as participating in community initiatives, vocational training, or engaging in income-generating activities to support their families. Social support from peers is essential for adolescents. Approximately two-thirds (65%) of teenagers reported spending time with their friends at least once a week to alleviate stress. Most teenagers have reliable connections with their parents, who are their main providers of assistance and support, as per findings of the research (Guglielmi et al., 2020).

Child-Friendly Spaces (CFSs) are designated safe zones within camps where communities build welcoming settings in which children can enjoy supervised games, outdoor leisure, and educational experiences. These venues are critical for providing psychological and social services to children in emergency contexts. CFSs provide structure, normalizing activities, safety, socialization, and adult supervision. They are considered essential for monitoring and assessing child safeguarding and protection issues and offering a secure place for play. BRAC, one of the world's largest non-governmental organisations (NGOs), collaborated with the LEGO Foundation, Sesame Workshop, and UNICEF to operate mental health and psychosocial support (MHPSS) programs and Humanitarian Play Laboratory

(HPLs) in 308 CFSs through 32 camps in Ukhiya and Teknaf regions in Cox's Bazar District, along with in local communities. About 60,000 children and their households received psychosocial assistance from these activities. BRAC launched the HPL in 2018 as an MHPSS approach that combines learning through play into the daily lives of children of all ages (Mariam et al., 2021). This methodology employs trained paraprofessional play leaders who present a learning-through-play model that combines "playfulness" and psychosocial assistance to address children's mental wellness concerns. The HPL has earned global recognition and appreciation for its novel approach to delivering psychological support and care for children through play in crisis and emergency situations (Frounfelker et al., 2019, p. 499).

Evidence and Methods of Providing Better Support

Urgent actions are required to provide both preventive and targeted psychosocial interventions to support children and their families, with continuous evaluation and monitoring of appropriateness and effectiveness of the provided support. The foundation for greater awareness of health and wellness can be established through education. By focusing on community development and individual capacity building, with specific attention to pre-adolescent boys and girls, integrating sports, leisure activities, and basic life skills into the curriculum can foster social cohesiveness and self-reliance (Shohel, 2020). Investment in community mentoring and peer-to-peer learning through nonformal education platforms is essential. Increasing adolescent support networks and promoting well-being can be achieved through the design of parent-adolescent support groups that encourage healthy interaction. Outreach to parents, religious leaders, and community leaders could be enhanced to boost support for teen empowerment programs in camps and host communities.

To meet the educational needs of underprivileged individuals, including teenage females, child laborers, disabled children, and households with children as their primary income earners, contemporary approaches such as e-learning might be adopted. Specialised programs could be created and implemented to focus on life skills, technical education, and fundamental literacy and numeracy, addressing real-life needs like setting up small-scale businesses and accessing e-knowledge networks. Providing livelihood-related social protection and safety-net programs for underprivileged refugee children and their host communities is necessary, as recommended in the grey literature (Greene et al., 2017) as well as unpublished reports from non-profit organizations and United Nations agencies. Addressing the high dropout rate among girls and supporting the over 52% of newly arriving refugee children and youth who are females requires more effective gender inclusion and specific interventions to empower adolescent girls (Guglielmi et al., 2019; Guglielmi et al., 2020; Shohel, 2022). Comprehensive training in trauma-informed care is essential for those assisting the displaced Rohingya communities and meeting their needs. Such training can provide workers with a better understanding of the lives of the Rohingya victims of gender-based violence and can help build trust between workers and survivors of gender-based violence, encouraging survivors to receive the health care services they require from programs tailored to their needs and improving the quality of care provided to the Rohingya communities (Anwary, 2022).

Ongoing critical research and innovative interventions in MHPSS will be necessary, focusing on well-being, education, livelihood opportunities, and work for children and young people (Shohel, 2023; Shohel et al., 2022). The policies and practices of the Bangladeshi government must evolve to support the needs and aspirations of the young Rohingya population. Policymakers in the government of Bangladesh must prioritize the various coping strategies and livelihoods adopted by the Rohingya population to survive in the camps. Targeted policy advocacy is essential to create an enabling environment for developing and implementing improved mental health interventions and market-based skills development programs for the young Rohingya populations. According to Khan et al. (2019), more than half of the 622 children examined had clinically significant emotional symptoms, and 25% had clinically significant peer problems, with these challenges being connected with being parentless.

It is critical to have a culturally accurate understanding of mental health, suffering, and guidance. When it comes to mental health care, community and outreach programs, as well as reimagining para-counselors and mental health professionals as "diller daktar" (heart doctors) and clinics as "shanti khana" (peace centers), are more significant and appreciated by the Rohingya people than traditional counseling and mental wellness centers (Frounfelker et al., 2019). Community-based services, such as lay counseling and meditation offered by trained local volunteers, can be part of fundamental psychosocial assistance. Establishing specialized refugee support groups to deliver beneficial psychological support therapies is also feasible. These support networks can offer culturally appropriate solutions to address mental health concerns that are often linked to marginalization (Ullah et al., 2023).

Paid employment offers both financial flexibility and the opportunity for social collaboration. Working provides hope, which is essential for recovering from mental illness, as employed refugees tend to exhibit fewer symptoms (Hossain et al., 2021). Prioritizing more funding for teen-friendly areas where young people can interact and develop new skills, particularly vocational ones, is necessary. Adolescent females who are already married could be given priority in safe-space, and outreach efforts could involve families, spouses, and community leaders (Guglielmi et al., 2020).

Efforts might be made to build bridges between the refugees and the local society, fostering social ties to prevent isolation (Korac, 2003). States must implement policies concerning children's survival, well-being, and protection, covering programs to improve access to basic needs. Prioritising the immediate humanitarian needs of the Rohingyas over the socio-cultural, historical and political issues is crucial for policymakers, stakeholders, donors, and international agencies, as meeting the needs are vital for survival and well-being of the Rohingya refugees (Ullah et al., 2022).

The Child and Youth Resilience Measure (CYRM) investigates the people and their environments to guard against negative mental wellness consequences. Concentrating on the 7 qualitative elements of endurance determined in the CYRM—access to material resources, relationships (with family and peers), identity, power and control, cultural adherence, social justice, and cohesion—can assist in developing interventions that encourage changes in society that improve adaptability. Improving access to education has also been shown to improve resilience (O'Connor & Seager, 2021).

The No Limit Generation (NLG) platform can provide aid workers, ECD professionals, educators, parents, and youth-serving professionals with essential training and resources for addressing child well-being. NLG's platform emphasizes the creation of safe, structured, and inclusive environments for children to play in daily, engaging children through informed, trustworthy, and supportive adults, and believing in children's potential to heal and lead fulfilling lives. The NLG platform aligns with mental health and psychosocial support standards and adheres to the core principles outlined in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Mansur, 2021).

To address the common mental health issues in the camp, psychiatric care and psychosocial assistance are essential. A consistent supply of psychotropic medications is crucial to meet the needs of individuals with severe mental health conditions. Providing larger rooms for child-friendly environments and group or parental activities is recommended.

Recommendations

Based on the extensive analysis of the well-being issues and challenges faced by the Rohingya refugee children and the coping mechanisms they have, the following recommendations are proposed:

Mental Health Training and Assessment

Mental health care staff should receive specialized training to routinely assess and address the unique needs of individuals suffering from various mental health conditions and symptoms, which are prevalent among those requiring mental health treatment. Training programs could equip professionals with the necessary skills to identify and provide support for common mental health conditions, including post-traumatic stress disorder, depression, and anxiety.

Comprehensive Support Plans

To address the therapeutic needs of individuals with severe mental health problems and conditions, comprehensive support plans must be developed and implemented. These plans must include strategies to eliminate barriers to accessing medical care and mental health services, ensuring that individuals receive the care and treatment they require.

Capacity Building for Mental Health Workers

Mental health workers in refugee camps should receive ongoing training and support to fulfill their vital role as caregivers for refugee children. This capacity building might include strategies for dealing with the psychological and emotional needs of children who have experienced trauma, loss, and displacement. Specialised training programs, workshops, and mentorship opportunities can enhance their ability to provide effective care and support.

Data Collection, Monitoring and Research

Research initiatives aim to collect and analyze data on mental health issues, coping strategies, and the overall well-being of refugee children. It is crucial to gather more updated and primary-level data from the perspectives of the Rohingya parents and teenage children who have faced trauma both in their home country and in the camps where they currently reside. These data can help in developing targeted interventions and support systems that address the specific needs and experiences of the Rohingya population.

Non-governmental organizations (NGOs), government agencies, and donors could collaborate to establish regular monitoring and data collection mechanisms for the physical and mental health of refugee children. Statistical and descriptive data could be collected periodically to assess the well-being of children in the camps and to measure the effectiveness of interventions and support programs. These data can guide evidence-based decision-making and resource allocation.

Promote Resilience and Social Cohesion

Programs that encourage social cohesiveness, peer support, and community bonding could be initiated. These programs can help refugee children build resilience and improve their emotional well-being by fostering connections with their peers, neighbors, and extended family members.

Access to Education and Play

Efforts could be made to enhance access to education within the camps. Structured routines, social interaction, and safe environments are essential components for the well-being of children. Education not only imparts knowledge and skills but also provides a sense of normalcy and hope for the future. Child-friendly spaces, sports activities, and recreational programs could also be made available to ensure that children can engage in play, express themselves, and develop essential life skills.

Promotion of Accessible E-Learning

Contemporary approaches such as e-learning could be utilized to provide access to education for marginalized groups, including teenage females, child laborers, disabled children, and households with children as primary income earners.

Support for Adolescent Girls

Considering the high dropout rate among girls and the significant proportion of adolescent girls among the refugee population, specific interventions aimed at empowering them are essential. These interventions might promote education, health, life skills, and gender equality to ensure the well-being and development of girls in the camps.

Psychiatric Care and Psychosocial Assistance

Comprehensive mental health care services could be provided to individuals with serious mental health conditions. This includes access to psychotropic medications and a consistent supply of these medications. Additionally, larger rooms might be designated for child-friendly environments and group or parental activities.

Building Social Ties with the Local Community

Encouraging refugees to establish social ties with the local community can help reduce their isolation. This can be achieved through community engagement and cultural exchange programs, which facilitate integration and support for the well-being of refugee children and their families.

Psychosocial Support

Local volunteers who have undergone training can provide community-based amenities like lay counseling and meditation. Specialised refugee assistance groups can deliver psychological support therapies that are culturally sensitive and relevant to mental health concerns associated with marginalization.

By implementing the above-mentioned recommendations, stakeholders can significantly improve the mental health and overall well-being of the Rohingya refugee children in Bangladesh, with a focus on building resilience, promoting social cohesion, and providing essential support and care. By adopting these above recommendations and prioritizing the mental health of these children, we can pave the way for their healing, resilience, and empowerment.

Conclusion

This article explores and highlights the critical well-being issues, challenges, and coping mechanisms of the Rohingya refugee children in Bangladesh, offering valuable insights into the multifaceted aspects of their lives in displacement. The unique experiences of these children, who have endured displacement, loss, and ongoing adversity, underscore the importance of understanding their coping mechanisms and providing essential support. The analysis reveals the substantial mental health issues prevalent among the Rohingya refugee children, with many displaying symptoms of post-traumatic stress disorder, depression, and anxiety. Limited access to education, separation from family members, and restricted living conditions within the camps contribute to their emotional distress. The well-being of these children is further affected by the lack of appropriate mental health care and psychosocial support, with only a minuscule portion of humanitarian aid allocated for mental health support.

However, the resilience and resourcefulness exhibited by the Rohingya children in forming social

networks and support systems are commendable. Social connections of the Rohingya children with their peers, neighbors, and extended family members provide emotional support and a sense of belonging, contributing to their ability to cope with the challenging circumstances they face. Additionally, religious and spiritual practices, as well as education through play and recreational activities, play a vital role in helping children process their experiences and build life skills. To improve the well-being of the Rohingya refugee children, this article offers a set of recommendations. These recommendations emphasize the need for specialized mental health training for staff, comprehensive support plans for those with severe mental health conditions, and ongoing capacity building for mental health workers. Data collection and research are crucial to tailoring interventions, and a regular monitoring system is essential to assessing the well-being of refugee children. Additionally, promoting resilience, social cohesion, and access to education, especially for adolescent girls, can significantly enhance their mental health.

The well-being of the Rohingya refugee children in Bangladesh requires our unwavering attention and dedicated efforts. Providing psychiatric care, psychosocial assistance, and initiatives to foster integration with the local community could be an integral part of a holistic support system to ensure the overall well-being of the Rohingya refugee children. By addressing their mental health needs, providing access to education, and fostering social connections, we can support these children on their journey toward a brighter and more hopeful future. The collective responsibility of governments, non-governmental organizations, donors, and the international community is to ensure that no child's well-being is left unaddressed, regardless of their circumstances.

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References

- Akhter, M., Uddin, S. M. N., Rafa, N., Hridi, S. M., Staddon, C., & Powell, W. (2020). Drinking water security challenges in Rohingya refugee camps of Cox's Bazar, Bangladesh. *Sustainability*, *12*(18), 7325. <https://doi.org/10.3390/su12187325>
- Amnesty International UK. (2018, June 14). From violence to exploitation: Sex trafficking of Rohingya children in Bangladesh. The Children's Human Rights Network Blog | 14 Jun 2018 | Amnesty International UK. Retrieved from <https://www.amnesty.org.uk/blogs/childrens-human-rights-network-blog/violence-exploitation-sex-trafficking-rohingya-children>
- Amnesty International. (2015). Stateless in Burma: Rohingya plight in a state of denial. Retrieved from <https://www.hrw.org/news/2015/01/13/burma-amend-biased-citizenship-law>
- Ansar, A., & Md. Khaled, A. F. (2021). From solidarity to resistance: host communities' evolving response to the Rohingya refugees in Bangladesh. *Journal of International Humanitarian Action*, *6*(1), 16. <https://doi.org/10.1186/s41018-021-00104-9>
- Anwary, A. (2022). Sexual violence against women as a weapon of Rohingya genocide in Myanmar. *The International Journal of Human Rights*, *26*(3), 400-419. Retrieved June 24, 2020 from <https://www.tandfonline.com/doi/abs/10.1080/13642987.2021.1931136>
- Asrar, S. (2017, October 28). Rohingya crisis explained in maps. Al Jazeera. Retrieved from <https://www.aljazeera.com/news/2017/10/28/rohingya-crisis-explained-in-maps>
- Beech, H. (2018, January 2). Rohingya children facing 'Massive mental health crisis.' The New York Times. Retrieved from <https://www.nytimes.com/2017/12/31/world/asia/rohingya-children-myanmar.html>
- Betancourt, T. S., & Khan, K. (2008). The mental health of children affected by armed conflict: Protective processes and pathways to resilience. *International Review of Psychiatry*, *20*(3), 317-328. <https://doi.org/10.1080/09540260802090363>
- Cairns, E. (2017). *I Still Don't Feel Safe to Go Home: Voices of Rohingya refugees*. Oxfam. <https://doi.org/10.21201/2017.1466>
- Chattoraj, D., Ullah, A. A., & Hossain, M. A. (2021). The COVID-19 pandemic and the travails of Rohingya refugees in the largest Bangladeshi refugee camp. In *Volume 1: Community and Society* (pp. 165-174). Bristol University Press. <https://doi.org/10.51952/9781529218893.ch015>
- Chen, D. H. (2018). *In Rohingya camps, traditional healers fill a gap in helping refugees overcome trauma*. The New Humanitarian. Retrieved from <https://www.thenewhumanitarian.org/feature/2018/07/30/rohingya-camps-traditional-healers-fill-gap-helping-refugees-overcome-trauma>
- Christensen, L. R., & Ahsan, H. (2022). Of numbers and moods: Screening for mental health issues in a Rohingya Refugee Camp in Bangladesh. *Medical Anthropology*, *41*(8), 854-865. <https://doi.org/10.1080/01459740.2022.2113396>
- Corbit, J. D., Didkowsky, N., Gora, V., Reddy, H., Saifullah, M., & Callaghan, T. C. (2022). Facilitating the prosocial development of Rohingya refugee children. *Journal of Experimental Child Psychology*, *220*, 105414. <https://doi.org/10.1016/j.jecp.2022.105414>
- Cox's Bazar Child Protection Sub Sector. (2021). Findings from the Child Protection Assessment in Rohingya Refugee Camps in Cox's Bazar. Retrieved from <https://reliefweb.int/report/bangladesh/findings-child-protection-assessment-rohingya-refugee-camps-cox-s-bazar-october>
- Dangmann, C., Dybdahl, R., & Solberg, Ø. (2022). Mental health in refugee children. *Current Opinion in Psychology*, *48*, 101460. <https://doi.org/10.1016/j.copsyc.2022.101460> Retrieved from <https://www.sciencedirect.com/science/article/pii/S2352250X22001816>
- Duchesne, B. (2016). *A rapid assessment on psycho-social needs and resources: Maungdaw and Buthidaung Townships: Executive summary*. Myanmar: ACF International.
- Dyer, G. M., & Biswas, M. (2019). Psychological and psychiatric care for Rohingya refugees in Bangladesh. *Intervention*, *17*(2), 217-224. https://doi.org/10.4103/intv.intv_30_19

- Fazel, M., & Betancourt, T. S. (2018). Preventive mental health interventions for refugee children and adolescents in high-income settings, *The Lancet Child & Adolescent Health*, 2(2), 121-132, [https://doi.org/10.1016/S2352-4642\(17\)30147-5](https://doi.org/10.1016/S2352-4642(17)30147-5).
- Fischer, L., Zarate, A., Mozumder, K., Elshazly, M. & Rosenbaum, S. (2021). Barriers, attitudes, confidence and knowledge of mental health and psychosocial humanitarian staff in Cox's Bazar in responding to suicide risk. *Intervention* 19(2): 242-248. https://doi.org/10.4103/INTV.INTV_53_20
- Frounfelker, R. L., Islam, N., Falcone, J., Farrar, J., Ra, C., Antonaccio, C. M., Ngozi Enelamah, N., & Betancourt, T. S. (2019). *Living through war: Mental health of children and youth in conflict-affected areas*. Retrieved from <https://international-review.icrc.org/articles/living-through-war-mental-health-children-and-youth-conflict-affected-areas>
- Goodman, A., & Mahmood, I. (2019). The Rohingya refugee crisis of Bangladesh: Gender based violence and the humanitarian response. *Open Journal of Political Science*, 9(3), 490-501. <https://doi.org/10.4236/ojps.2019.93027>
- Green, L., McHale, T., Mishori, R., Kaljee, L., & Akter Chowdhury, S. (2022). "Most of the cases are very similar": Documenting and corroborating conflict-related sexual violence affecting Rohingya refugees. *BMC Public Health*, 22(1), 700. <https://doi.org/10.1186/s12889-022-13038-7>
- Greene, M. C., Jordans, M. J., Kohrt, B. A., Ventevogel, P., Kirmayer, L. J., Hassan, G., Chiumento, A., Ommeren M.V. & Tol, W. A. (2017). Addressing culture and context in humanitarian response: preparing desk reviews to inform mental health and psychosocial support. *Conflict and Health*, 11, 1-10. <https://doi.org/10.1186/s13031-017-0123-z>
- Guglielmi, S., Jones, N., Muz, J., Baird, S., Mitu, K., & Ala Uddin, M. (2020). "How will my life be?": Psychosocial well-being among Rohingya and Bangladeshi adolescents in Cox's Bazar. *Policy Brief. London: Gender and Adolescence: Global Evidence*. Retrieved from https://www.gage.odi.org/wp-content/uploads/2020/04/%E2%80%98How-will-my-life-be_%E2%80%99-Psychosocial-well-being-among-Rohingya-and-Bangladeshi-adolescents-in-Cox%E2%80%99s-Bazar.pdf
- Guglielmi, S., Muz, J., Mitu, K., Ala Uddin, M., Jones, N., Baird, S., & Presler-Marshall, E. (2019). The lives they lead: Exploring the capabilities of Bangladeshi and Rohingya adolescents in Cox's Bazar, Bangladesh. *Gender and Adolescence: Global Evidence*. https://www.gage.odi.org/wp-content/uploads/2019/12/GAGE-Rohingya-brief_WEB.pdf
- Haider, S., Maheen, A., Ansari, M., & Stolley, M. (2023). Health beliefs and barriers to healthcare of Rohingya refugees. *Journal of Racial and Ethnic Health Disparities*, 10(4), 1560-1568. <https://doi.org/10.1007/s40615-022-01342-2>
- Hossain, A., Baten, R. B. A., Sultana, Z. Z., Rahman, M. T., Adnan, M. F., Hossain, M. M., Khan, T. A., & Uddin, M. K. (2021). Predisplacement abuse and postdisplacement factors associated with mental health symptoms after forced migration among Rohingya refugees in Bangladesh. *JAMA Network Open*, 4(3), e211801. <https://doi.org/10.1001/jamanetworkopen.2021.1801>
- Hossain, I. (2023). The impact of the Rohingya refugee crisis on mental health. *The Business Standard*, Retrieved December 19, 2023 from <https://www.tbsnews.net/thoughts/impact-rohingya-refugee-crisis-mental-health-760330>
- Human Rights Council. (2018). Report of the detailed findings of the Independent International Fact-Finding Mission on Myanmar. [Document Ref. A/HRC/39/CRP.2]
- Human Rights Watch. (2000). Burmese Refugees in Bangladesh: Still No Durable Solution, *HRW*, 12 (3C). Retrieved from <https://www.hrw.org/reports/2000/burma/index.htm>
- Human Rights Watch (HRW). (2018). "Bangladesh Is Not My Country" The plight of Rohingya Refugees from Myanmar. Retrieved from <https://www.hrw.org/report/2018/08/05/bangladesh-not-my-country/plight-rohingya-refugees-myanmar>
- Humanity and Inclusion (HI). (2019). Mental health and psychosocial support field assessment: Distress prevalence, stressors, and coping mechanisms among the Rohingya community in Cox's Bazar, Bangladesh. Retrieved from https://www.hi.org/sn_uploads/document/2019_HI-Network_Annual-Report.pdf
- International Organization for Migration (IOM). (2018). Mental health and psychosocial support needs assessment of Rohingya refugees in Cox's Bazar, Bangladesh. Retrieved from <https://migration.iom.int/reports/bangladesh->

mental-health-and-psychosocial-support-needs-assessment-rohingya-refugees-coxs

- International Organization for Migration (IOM). (2021). Mental health and psychosocial support needs assessment. Retrieved from <https://reliefweb.int/report/bangladesh/iom-needs-assessment-report-mental-health-and-psychological-support-june-2021>
- Islam, M. M., Barman, A.; Khan, M.I.; Goswami, G.G.; Siddiqi, B.; Mukul, S.A. (2022). Sustainable livelihood for displaced Rohingyas and Their resilience at Bhashan Char in Bangladesh. *Sustainability*, 14, 6374. <https://doi.org/10.3390/su14106374>
- Joarder, T., Sutradhar, I., Hasan, M. I., & Bulbul, M. M. I. (2020). A record review on the health status of Rohingya refugees in Bangladesh. *Cureus*, 12(8). <https://doi.org/10.7759/cureus.9753>
- Joint Government of Bangladesh - UNHCR Population Factsheet as of March 2023. (2023, March 31). UNHCR Operational Data Portal (ODP). <https://data.unhcr.org/en/documents/details/100047>
- Khan, N. Z., Shilpi, A. B., Sultana, R., Sarker, S., Sultana, R., Roy, B., Arif, A., Ahmed, M. U., Saha, S. C., & McConachie, H. (2018). Displaced Rohingya children at high risk for mental health problems: Findings from refugee camps within Bangladesh. *Child: Care, Health and Development*, 45(1), 28–35. <https://doi.org/10.1111/cch.12623>
- Khan, N.Z., Shilpi, A.B., Sultana, R., Sarker, S., Razia, S., Roy, B., Arif, A., Ahmed, M.U., Saha, S.C. & McConachie, H. (2019). Displaced Rohingya children at high risk for mental health problems: Findings from refugee camps within Bangladesh. *Child: Care, Health and Development*, 45(1),28-35. <https://doi.org/10.1111/cch.12623>
- Khan, S., & Haque, S. (2021). Trauma, mental health, and everyday functioning among Rohingya refugee people living in short-and long-term resettlements. *Social Psychiatry and Psychiatric Epidemiology*, 56, 497-512. <https://doi.org/10.1007/s00127-020-01962-1>
- Kinch, T. L. (2008). *Linking invisibility and vulnerability: strengthening refugee child protection capacity: the case of unaccompanied and separated refugee children from Bhutan living in Nepal*. Retrieved from https://library2.smu.ca/bitstream/handle/01/22382/kinch_tara_1_masters_2008.PDF?sequence=1&isAllowed=y
- Kiragu, E., Rosi, A. L. & Morris, T. (2011). *States of denial- A review of UNHCR's response to the protracted situation of stateless Rohingya refugees in Bangladesh*. UNHCR, Geneva, Switzerland. Retrieved from <http://www.unhcr.org/4ee754c19.pdf>
- LCFA. (2018). *Learning competency framework and approach: For children of displaced person's from Myanmar in Bangladesh*. Retrieved from <https://continuityineducation.org/articles/10.5334/cie.57>
- Mansur, S. (2021). *Accessible Strategies to Support Children's Mental Health and Wellbeing in Emergencies: Experience from the Rohingya Refugee Camp*. Retrieved from <https://archive.nyu.edu/handle/2451/62227>
- Mariam, E., Ahmad, J., & Sarah Sarwar, S. (2021). BRAC Humanitarian Play Lab Model: Promoting Healing, Learning and Development for Displaced Rohingya Children. *Inter-agency Network for Education in Emergencies (INEE)*, 7(1),133-149. <https://doi.org/10.33682/u72g-v5me>
- Masood, S. M. U., & Uddin, M. S. (2020). International Response to Humanitarian Crisis: A study of Rohingya Issue. *Being Immigrant in the World: Experiences, Challenges and Opportunities*, 1, 143-164. https://www.researchgate.net/profile/Muhammad-Uddin-41/publication/366790727_International_Response_to_Humanitarian_Crisis_A_study_of_Rohingya_Issue/links/63b286a1c3c99660ebc08dd1/International-Response-to-Humanitarian-Crisis-A-study-of-Rohingya-Issue.pdf
- Mazhar, M. K. A., Finger, F., Evers, E. S., Kuehne, A., Ivey, M., Yesurajan, F., Shirin, T., Ajim, N., Kabir, A., Musto, J., White, K., Baidjoe, A., & le Polain de Waroux, O. (2021). An outbreak of acute jaundice syndrome (AJS) among the Rohingya refugees in Cox's Bazar, Bangladesh: Findings from enhanced epidemiological surveillance. *PloS one*, 16(4), e0250505. <https://doi.org/10.1371/journal.pone.0250505>
- Médecins Sans Frontières (MSF). (2022). *Timeline: A visual history of the Rohingya refugee crisis*. Retrieved from <https://www.doctorswithoutborders.org/latest/timeline-visual-history-rohingya-refugee-crisis>
- Milton, A., Rahman, M., Hussain, S., Jindal, C., Choudhury, S., Akter, S., Ferdousi, S., Mouly, T., Hall, J., & Efird, J. (2017). Trapped in statelessness: Rohingya refugees in Bangladesh. *International Journal of Environmental*

Research and Public Health, 14(8), 942. <https://doi.org/10.3390/ijerph14080942>

- Moniruzzaman, H. M. (2021). *Education for Rohingya displaced children: A case study on providing education at NGO-run Temporary Learning Centres (TLCs) in Bangladeshi Refugee Camps*. [Master's Dissertation, University of Gothenburg]. Retrieved from University of Gothenburg. <https://gupea.ub.gu.se/handle/2077/69374>
- Murray, J. S. (2016). Displaced and forgotten child refugees: A humanitarian crisis. *Journal for Specialists in Pediatric Nursing*, 21(1), 29-36. <https://doi.org/10.1111/jspn.12133>
- O'Connor, K., & Seager, J. (2021). Displacement, violence, and mental health: evidence from Rohingya adolescents in Cox's bazar, Bangladesh. *International journal of environmental research and public health*, 18(10), 5318. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8156348/>
- Rahman, A., Khaled, N., Akter, M., Yesmin, S., Zaman, S. S., Marium, E., & Afsana, K. (2023). The well-being of Rohingya children in Rohingya camps of Bangladesh during the Covid 19 pandemic: a qualitative exploration. *Early Child Development and Care*, 193(4), 463-476. Retrieved from <https://www.tandfonline.com/doi/pdf/10.1080/03004430.2022.2106979>
- Rahman, M. R. (2018). Forcibly displaced Myanmar Nationals (FDMN's) to Bangladesh health sector response & challenges. *Journal of Bangladesh College of Physicians & Surgeons*, 36(3), 91-93. <https://doi.org/10.3329/jbcps.v36i3.37030>
- Reid, K. (2023, September 22). Rohingya refugee crisis: Facts, FAQs, and how to help. World vision. Retrieved from <https://www.worldvision.org/refugees-news-stories/rohingya-refugees-bangladesh-facts>
- Riley, A., Akther, Y., Noor, M., Author, F., & Welton-Mitchell, C. (2021). Mental health and conditions in refugee camps matter when Rohingya living in Bangladesh consider returning to Myanmar. Retrieved from <https://odihpn.org/publication/mental-health-and-conditions-in-refugee-camps-matter-when-rohingya-living-in-bangladesh-consider-returning-to-myanmar/>
- Riley, A., Varner, A., Ventevogel, P., Taimur Hasan, M. M., & Welton-Mitchell, C. (2017). Daily stressors, trauma exposure, and mental health among stateless Rohingya refugees in Bangladesh. *Transcultural psychiatry*, 54(3), 304-331. Retrieved from <https://journals.sagepub.com/doi/abs/10.1177/1363461517705571>
- Ritsema, H., & Armstrong-Hough, M. (2023). Associations among past trauma, post-displacement stressors, and mental health outcomes in Rohingya refugees in Bangladesh: A secondary cross-sectional analysis. *Frontiers in Public Health*, 10, 1048649. <https://doi.org/10.3389/fpubh.2022.1048649>
- Save the Children. (2019). Joint participatory child protection assessment with Rohingya adolescents. Retrieved from https://resourcecentre.savethechildren.net/pdf/final_cxb_participatory_cp_assessment_with_rohingya_adolescents.pdf/
- Shakespeare-Finch, J., Schweitzer, R. D., King, J., & Brough, M. (2014). Distress, coping, and posttraumatic growth in refugees from Burma. *Journal of Immigrant & Refugee Studies*, 12(3), 311-330. <https://doi.org/10.1080/15562948.2013.844876>
- Shohel, M. M. C. (2010). *Transition from nonformal to formal education in Bangladesh: An exploration of the challenges students face*. Lambert Academic Publishing.
- Shohel, M. M. C. (2022). Education in emergencies: Challenges of providing access to education for Rohingya refugee children living in refugee camps in Bangladesh. *Education Inquiry*, 13(1):104-126. <https://doi.org/10.1080/20004508.2020.1823121>.
- Shohel, M. M. C. (2023). Lives of the Rohingya children in Limbo: Childhood, education and children's rights. *Prospects*, 53(1): 131-149. <https://doi.org/10.1007/s11125-022-09631-8>.
- Shohel, M. M. C., Babu, R., Ashrafuzzaman, M., Azim, F., & Bayezid, A. (2023a). Learning competency framework and approach for the displaced Rohingya children living in Bangladesh: A critical review. *Continuity in Education*, 4(1), 50-66. <https://doi.org/10.5334/cie.57>
- Shohel, M. M., Ashrafuzzaman, M., Azim, F., Akter, T., & Tanny, S. F. (2022). Displacement and Trauma: Exploring the Lost Childhood of Rohingya Children in the Refugee Camps in Bangladesh. In R. Throne (Ed.), *Social Justice*

- Research Methods for Doctoral Research* (pp. 244-272). IGI Global. <https://doi.org/10.4018/978-1-7998-8479-8.ch012>
- Shohel, M. M., Ashrafuzzaman, M., Babu, R., Akter, T., Tasnim, N., & Bayezid, A. (2023). Access to higher education for the Rohingya refugees: Challenges, opportunities, and future directions. In S. Saeed & M. Zhang (Eds.), *Global perspectives on the difficulties and opportunities faced by migrant and refugee students in higher education* (pp. 103-135). IGI Global. <https://doi.org/10.4018/978-1-6684-7781-6.ch005>
- Snow, A., & Sissons, J. (2012). Bringing health care to displaced people in Burma. *Kai Tiaki Nursing New Zealand*, 18(2), 30. Retrieved from <https://pubmed.ncbi.nlm.nih.gov/22675882/>
- Tachè, J. & Selye, H. (1985) On stress and coping mechanisms. *Issues in Mental Health Nursing*, 7(1-4), 3-24, <https://doi.org/10.3109/01612848509009447>
- Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., Varner, A., Silove, D., & Ventevogel, P. (2018). *Culture, context and mental health of Rohingya refugees: A review for staff in mental health and psychosocial support programmes for Rohingya refugees*. Geneva, Switzerland. United Nations High Commissioner for Refugees (UNHCR).
- Tay, A. K., Riley, A. F., Islam, R., Welton-Mitchell, C., Duchesne, B., Waters, V., Varner, A., Moussa, B., Alam, A., Elshazly, M., Silove, D., & Ventevogel, P. (2019). The culture, mental health and psychosocial wellbeing of Rohingya refugees: a systematic review. *Epidemiology and Psychiatric Sciences*, 28(5), 489–494. <https://doi.org/10.1017/s2045796019000192>
- Ullah, A. N. Z., Pratley, P., Islam, M. S., Islam, K., & Roy, T. (2023). Exploring mental health status and psychosocial support among Rohingya refugees in Bangladesh: A Qualitative study. *Mental Illness*, 2023, 1–8. Retrieved from <https://www.hindawi.com/journals/mij/2023/6128286/>
- Ullah, A.A. and Chattoraj, D. (2022). The Plight of Myanmar's Rohingya Children. In *Routledge Handbook of Islam in Southeast Asia* (pp. 190-202). Routledge. Retrieved from <https://www.taylorfrancis.com/chapters/edit/10.4324/9780429275449-14/plight-myanmar-rohingya-children-ahsan-ullah-diotima-chattoraj>
- UN Joint Response Plan. (March-December 2018). *Joint Response Plan*. Retrieved from <http://www.unhcr.org/uk/partners/donors/5ab8e23a7/2018-jointresponse-plan-rohingya-humanitarian-crisis-march-december-2018.html>
- UN Women. (2018). *Gender Brief on Rohingya Refugee Crisis Response in Bangladesh*. Retrieved from <http://asiapacific.unwomen.org/en/digital-library/publications/2017/10/gender-brief-on-rohingya-refugee-crisis#view>
- UNDP. (2018). *Impacts of the Rohingya refugee influx on host communities*. Retrieved from <https://www.undp.org/sites/g/files/zskgke326/files/migration/bd/Impacts-of-the-Rohingya-Refugee-Influx-on-Host-Communities.pdf>
- UNHCR. (2018). *Mental health and psychosocial support for refugees, asylum seekers and migrants*. Retrieved from <https://www.unhcr.org/5b259d7c7.pdf>
- UNHCR. (2020). *Mental health and psychosocial support needs and services for Rohingya refugees in Cox's Bazar, Bangladesh*. Retrieved from <https://data2.unhcr.org/en/documents/details/79667>
- UNHCR's Population Statistics. (15 July 2018). *Bangladesh Refugee Emergency: Population Factsheet*. <https://data2.unhcr.org/en/documents/download/64838>
- UNICEF. (2017a). World's second largest oral cholera vaccination campaign kicks off at Rohingya camps in Bangladesh, *Joint press release from World Health Organization and UNICEF*. <https://www.unicef.org/press-releases/worlds-second-largest-oral-cholera-vaccination-campaign-kicks-off-rohingya-camps>
- UNICEF. (2017b). *A child is a child: Protecting children on the move from violence, abuse and exploitation*. Retrieved from https://www.unicef.org/media/49571/file/UNICEF_A_child_is_a_child_May_2017_EN.pdf
- UNICEF. (2021). *Findings from the child protection assessment in Rohingya Camps in Cox's Bazar*. Retrieved from <https://reliefweb.int/report/bangladesh/findings-child-protection-assessment-rohingya-refugee-camps-cox-s-bazar-october>
- Wake, C., & Cheung, T. (2016). *Livelihood strategies of Rohingya refugees in Malaysia: 'We want to live in*

dignity'. Retrieved from <https://reliefweb.int/sites/reliefweb.int/files/resources/10655.pdf>

Zaman, K. T., Hasan, W. U., Bazlul, L., Motahar, T., & Ahmed, N. (2019). Exploring challenges and solution approaches regarding wellbeing of Female Rohingya Community in Bangladesh. In *TENCON 2019-2019 IEEE Region 10 Conference (TENCON)* (pp. 361-366). IEEE. <https://doi.org/10.1109/tencon.2019.8929413>